DOCUMENT RESUME

ED 314 587 CE 053 870

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TITLE What Information Should a Certification Program Provide to Schools and Accreditation Bodies? Needs for Establishing Cooperative Linkages.
PUB DATE 2 Dec 89
NOTE 13p.; Paper presented at the Annual Conference of the National Organization for Competency Assurance (2nd, Alexandria, VA, December 1-2, 1989).
PUB TYPE Viewpoints (120) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Accrediting Agencies; *Certification; *Competence; Confidentiality; *Cooperation; Educational Certificates; Eligibility; Employment Qualifications; *Health Occupations; *Health Personnel; Licensing Examinations (Professions); Quality Control; Standards; State Licensing Boards

ABSTRACT

The production of a competent health practitioner requires effective cooperative effort from certifying agencies, accrediting agencies, and educational institutions. Information exchange among certifiers, accreditors, educators, and employers should be liberal. Such exchange must not violate confidentiality, especially in the matter of documents, such as references obtained to verify compliance to standards or criteria required of a candidate, school/program, or employment in evaluating eligibility for certification, accreditation, or employment. An external influence that is currently receiving attention in the production and practice of health care professionals is independent practice. Professional associations, certifying agencies, accrediting agencies, educators, employers, third-party payers, and consumers must be involved in making the decision about independent practice. The goal of credentialing is competency. The competent practitioner is the product resulting from the best cooperative efforts of educators, accreditors, and certifiers. The competent practitioner in all probability is a member of a professional association and participates to some degree in the various activities and programs of the association. The competent practitioner is aware of the rapid changes in technology and the delivery of health services and is an advocate of programs designed to maintain continued competency. (CML)

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CERTIFICATION STRATEGIES FOR THE '90s
Saturday, December 2, 1989

"What Information Should a Certification Program Provide to Schools and Accreditation Bodies?"

Needs for Establishing Cooperative Linkages

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Introduction--Relationships among Elements

"The Board's registration examination will not be truly effective until it is such a good measure of knowledge, techniques and attitudes that it can be opened to everyone, irrespective of the route he traveled to gain the requisite knowledge, techniques and attitudes, or of the time involved in doing so." This quote is attributed to Dr. George P. Vennart, Chairman of the Board of Registry of Medical Technologists and was taken from a 1970 Study on Equivalency and Proficiency testing related to the Medical Laboratory Field. Let me repeat a key phrase in that quote: "The route he traveled to gain the requisite knowledge, techniques and attitudes." Far too often we tend to ignore the variety of training methods used to prepare health care providers. It is to NCHCA's credit that its criteria recognize the value of certification to individuals who have obtained skills and knowledge outside the formal educational setting. These non-traditional routes present a challenge to certifiers for continued research and refinement of our testing methods.

In addressing the topic, "What Information Should a Certification Program Provide to Schools and Accreditation Bodies," it may be appropriate to look at cooperative linkages that should be established between certification programs, schools, accrediting bodies and employers. These cooperative linkages are important if our ultimate goals is to produce a competent practitioner. I included the employer because the production of a practitioner is of little value unless the employer can use the product we educate, train, and credential. Satisfying the employer should be one of our major commitments. As one of the gears in a well-oiled machine the employer must play a key role in the credentialing process.

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As you observe, in Figure 1, I place the employer in the center of my schematic relationship among the entities that interact in the production of a practitioner. All of this interaction occurs under the watchful eye of the consumer, the user of the health care service that the practitioner provides.

Employer and consumer interest becomes significant in the education/credentialing arena if, indeed, our efforts and energies are directed toward the protection of the public and the delivery of quality health care.

In my remarks that follow, three areas will be explored:

1. The production of an ideal product--a competent practitioner --requires effective cooperative effort from certifying agencies, accrediting agencies and educational institutions.

2. Some of the external influences that impact on the production and practice of professionals.

3. A look ahead into the '90s - A viewpoint.

In considering the first area mentioned, the production of an ideal product, the essential element is credentialing. Credentialing is composed of two basic forms, each of which possesses alternatives: The first is Educational--The process is identified as accreditation. Educational resources are evaluated and recognized in terms of predetermined criteria including standards for facilities, faculty, and curricula. Two types of accreditation exist: Institutional and Programmatic.

The second form of credentialing is centered on Personnel--This is the process through which individuals, who may or may not be products of formal educational programs, are determined to fulfill established criteria and standards for performance. As with accreditation, there are two types of personnel credentialing: Certification and Licensure.

No attempt will be made here to discuss, let alone attempt to resolve some of the time-worn debates which credentialing has spawned. If accreditation is effectively implemented, why do we need certification? And, conversely, if certification is effectively implemented, why do we need accreditation? Finally, licensure sometimes utilizes both accreditation and certification, although the latter usually has a lesser role because of strong influence from advocates of strict educational standards.

While there may be disagreement among agencies and associations as to the appropriate level of education one needs to enter a specific health occupation/profession, these can become a major problem if more than one agency and/or association is representing a specific health discipline. It is not uncommon to find that turf battles between associations/agencies, certifiers and accreditors exist and are a way of life in the credentialing

community. In some instances the latter prevents a free and unrestrained exchange of information, even though all our energies supposedly are directed toward the production of the best employee our individual efforts can produce.

Because of my 26-plus years as executive director of a certifying organization, let me use that experience to illustrate the way in which the process can work.

As a certifying agency that provides membership benefits to its certificants, American Medical Technologists (AMT) has both an obligation and duty to share information with our accrediting agency, the schools which the agency accredits, particularly these schools whose graduates seek certification with AMT, employers and the consumers of health services. In return, AMT relies on the accrediting agency, schools, employers and consumers for information that will enhance our certification programs. All of these elements are interdependent in the credentialing process. Let me briefly comment on 12 key areas in the credentialing process:

#1. Pass/Fail ratios on certifying examinations for graduates of accredited schools and/or programs--this can be used by the school and the accrediting agency as an external validation of the quality of the education program.

#2. Any proposed changes in standards qualifying individuals for certification. Reactions from accreditors and educators should be welcomed and considered before final changes are approved for implementation.

#3. Make available a list of certified individuals to act as content experts on accreditation teams.

#4. Propose a list of qualified individuals to be considered for vacancies on the accrediting boards.

#5. Provide an avenue for reviewing any proposed changes being contemplated by accrediting boards in their criteria for evaluating schools and/or programs.

#6. Support in the legislative and/or legal arena.

#7. As new technologies, procedures and products are introduced into the profession, new competency statements must be developed. These competencies should be shared with educators and accrediting agencies so that educational programs can be adjusted accordingly.

#8. Employer and Educator cooperation in validating certifying examinations is necessary and valuable to certifiers.

#9. Employer requests for verification of employee certification and/or employee participation in continuing education programs--such information is becoming increasingly important for accreditation of health care facilities.

#10. Schools, accrediting agencies, and certification agencies should collaborate in defining occupational scopes of practice. This incorporates the delineation of task and knowledge areas required for successful practice.

#11. Schools may serve as a source of subject-matter experts for certification agencies. These experts can guide examination development, write examination items, and determine standards related to the credentialing of practitioners.

#12. Overall, it is important to have an ongoing exchange between practitioners and educators to maintain realistic and appropriate standards in the credentialing of entry-level individuals.

In summary, information exchange among certifiers, accreditors, educators and employers should be liberal, providing such exchange does not violate confidentiality, especially in the matter of documents, references obtained to verify compliance to standards/or criteria required of a candidate, school/program or employer in evaluating eligibility for certification, accreditation or employment.

It is important that requests for information be in writing unless previous arrangements between a certifying agency, accrediting agency, school and employers were made to share certain data on a regularly-scheduled basis.

Information exchange is important if:

1. It is vital to a research project and/or study.

2. It will improve the efficiency and/or quality of a program.

3. It has a bearing on legislative activity affecting the credentialing process and employability of practitioners.

4. It responds to satisfying the needs of a consumer or third party payor of health care costs.

Other sources of information that credentialing organizations, educators and employers utilize come from professional associations and practitioners. Programs for assessing continuing competence, initiatives and government regulation contribute to the pool of information necessary for the production of the entry-level practitioner.

Professional associations were the prime movers in developing certifying and accrediting agencies. They are in touch, through a variety of organizational structures, with the

grassroots practitioners. They are a principle source of information on advances in technology and/or variations within the practice of a particular discipline. Associations provide information on what it takes to do the job; suggest ways to improve the practice/profession; recommend knowledgeable practitioners to sit on certifying and accrediting boards and can lend support to certifiers and accreditors on legislative and/or legal matters. They are also sources of important information for consumers and provide a valuable communication link between individual employers and employees in a variety of health care facilities.

At the start of this talk I mentioned external influences that can affect the production and practice of health care professionals. Two such factors that are currently receiving attention, at least in the medical laboratory field, are independent practice and licensure, both causes being promoted by some groups. I will briefly address licensure later in the presentation. With regard to independent practice, every professional association, certifying agency, accrediting agency, the educators, employers, third party payors, and consumers must be involved in making the decision; yes--we must be independent practitioners or no--the good of the consumer as well as our professional needs are better served by being an important part of the health care team.

The debate on the Independent Practice issue continues, and it is not the purpose of this presentation to offer a position pro or con. It is, however, in keeping with the presentation on cooperative initiatives to present some critical questions that impact on the debate, on credentialing groups, employers and consumers. For example:

#1. Is the public interest best served by independent allied health practitioners? If the answer is yes--should this apply to all or just a select few allied health occupations?

#2. Are proponents of independent practice using the academic models peculiar to and popularized by medicine, dentistry, law and religion? How will this impact on manpower and the cost of delivering a particular service?

#3. How altruistic are the motives of the associations that advocate this approach for their members/profession?

#4. Will independent practice initiatives be incorporated in personnel licensure?

Again, it should be emphasized that professional associations in concert with credentialing organizations and employers must address the critical issue: Does independent practice serve the public need? Will the competitive nature of the movement improve health care delivery service?

While associations play a critical role in standards and policy-making for their constituencies and whether an association is the only group representing the profession, or whether the profession is represented by multiple associations, it is important for the

latter to remember that they only represent their constituents and should make no pretense of speaking for the profession as a whole.

It is most important for associations, credentialing entities, educators and employers to cooperate in reaching a unanimous decision and/or a consensus on matters that affect the practitioners' right to practice, regardless of any affiliation, or lack of affiliation, such practitioner may have.

Whatever the trend or influence of the moment, the goal all of us must keep in mind is competency. The competent practitioner is the product resulting from the best cooperative efforts of educators, accreditors and certifiers. The competent practitioner in all probability is a member of a professional association and participates to some degree in the various activities and programs of the association. The competent practitioner is aware of the rapid changes in technology and the delivery of health services and is an advocate of programs designed to maintain continued competency. Through membership in associations they affect policies and programs that impact on the practitioner, the profession, and the education and credentialing of the entry-level practitioner.

Thus, the association and its membership must maintain open lines of communication that will assist the credentialing entities in making the necessary adjustments to keep attuned to rapid changes in technology and the delivery of health care.

In turn, the individual practitioner has a responsibility to educators, certifiers and accreditors. When seasoned practitioners meet entry-level practitioners, it is vital that they project a positive professional image of the profession and its members. This will greatly influence the manner in which the new employee views the delivery of health care in a particular facility.

I will emphasize only two points:

> The first is the value of patience. It is important to have this virtue when initiating a new employee to the rules/regulations of the institution; the specific department in which the new employee will put to practice his/her knowledge and skills; to what degree they meet the needs of the department; and the amount of additional training should this be necessary, needed to fulfill the goal. Patience will reap rewards.
>
> Secondly, the practitioner should be a constructive critical observer of the entry-level practitioner. Any information that he/she believes will improve the quality of the new practitioner should be relayed either through the professional association or personally to the educators, accreditors or certifiers as the case may warrant. Again, the competent practitioner is one key to evaluating the final product of the combined efforts of the education/credentialing system.

In a series of two articles on the topic of occupational certification authored by Neil Weisfeld, former associate executive director of NCHCA, and Dennis Falk, former Executive Director of NCHCA, the second of these articles appeared in the March 1983 issue of Hospital and was titled, "Chasing elusive competence--Recertification assures competence where continuing education cannot." I quote from the article: "The national Commission for Health Certifying Agencies has developed comprehensive criteria to judge the fairness, validity, reliability, and other aspects of credentialing programs. But even credentialing agencies have not justified a link between their certificates and continuing competence."

Where are we in our quest of elusive competence? Does recertification assure competence where continuing eduction cannot?

Expanding continuing eduction delivery systems will remain a major factor in assessing competency as we plan our certification strategies for the '90s. I believe that continuing education will remain an important factor if and when certifying organizations adopt mandatory recertification programs.

In conjunction with the latter statement there are obstacles that must be overcome. Some of the areas of concern are:

#1. Certifying agencies must adopt a policy issuing initial certificates with time limitations. Periodic renewals would be based on an assessment mechanism used in the initial certification or some modification of the original.

#2. Recertification programs should take into account any changes in the certificant's practice and/or in the employment situation. As an example, one might be granted an original certificate as a generalist medical technologist. Subsequent to the original certification the individual may specialize in one or several of the disciplines that define medical technology, become supervisors or managers, own and operate a laboratory. The particular site in which the certificant practices may also impact on how the recertification program is designed.

#3. If indeed recertification assures competence, then federal and state government employers, third party payers and malpractice carriers must start demanding proof of continued competence as a condition of full payment, coverage, or recognition. Then professions will be motivated to increase the pace of making recertification a reality.

#4. Another area of difficulty involves the revocation of a credential. This requires careful attention to the drafting of standards that will apply to the recertification program(s).

Our records show that large numbers of certificants participate in continuing education, to some degree. However, a much smaller proportion of certificants comply fully with the

revalidation criteria. Because of the voluntary nature of a particular program and the associated lack of sanctions, practitioners may lack motivation to fully comply with the criteria.

The very difficult task now before researchers is to demonstrate the effects and efficacy of participation in continuing education activities. Once the efficacy of continuing education is demonstrated beyond a face valid (or common-sense appeal) position, perhaps practitioner motivation in this area will improve.

Again, let me draw upon my experience with one association's program of continuing education and recertification:

> In AMT's voluntary revalidation of certificate program, we require our registrants to earn 7 Continuing Education Credits during a five-year cycle. One can earn all 7 credits if one sits for a revalidation examination. The examination is modeled after our entry-level certifying examination, and consists of five sections covering the five content areas. Each section is assigned 1.4 credits. In addition to CE program, we have tried to encourage our registrants to sit for these revalidation examinations by eliminating the concept of pass or fail the examination in entirety that makes practitioners hesitant to sit for examinations. Each section of the examination is graded individually and the registrant gets credit for those sections he/she passes. With all of the emphasis on continuing education and continued competency generated in the '80s and with some very innovative programs utilizing computers and various self-assessment mechanisms, the chase for elusive competence may result in a catch during the '90s.
>
> It is important that educators, accreditors, employers and consumers are made aware of the efforts of certifying organizations and professional associations in assessing continued competency.
>
> The last of the issues that impact on the production and practice of health care practitioners is Licensure/Regulations.
>
> Licensure, as a rule, is proposed by Professional Associations to regulate a particular practice, and it always (and I say this with tongue-in-cheek) affects the public health, safety and welfare, and is subject to control and regulation in the public interest.
>
> Probably no other allied health profession is as regulated as is medical technology. With the exception of about one-half dozen states that require medical technology practitioners to be licensed, there are a variety of federal and state regulations applicable to all clinical laboratories and personnel except those labs operated by a physician within his/her practice.

In 1988 the Clinical Laboratory Improvement Act (CLIA) was enacted by Congress, and the profession is eagerly awaiting the publication of the regulations to implement the Act, the Act does provide for the regulation of physician office laboratories. The extent to which the regulations will impact on personnel is not known at this time. All states must comply with the regulations unless states provide for more stringent laws than those required by the Federal Government.

If one is a proponent of licensure for allied health practitioners, it is vital that communications between educators, certifiers, associations, employers and consumers be maintained and that consensus be reached and be reflected in the draft legislation.

Reaching consensus on a legislative initiative is crucial if there is more than one association, one certifying agency, and one accrediting agency for a particular allied health profession.

As an example, in medical technology there are:

- four associations and four certifying agencies representing generalist medical technologists and medical laboratory technicians
- two accrediting agencies
- at least three organizations representing management personnel
- two organizations representing independent laboratories, and
- at least seven major specialty organizations representing the various disciplines in medical technology. Some of these certify individuals in these specialties.

It is estimated that the above organizations represent between 250,000 to 300,000 members. These include training and/or educational programs ranging from private health career and vocational schools to post-baccalaureate programs. Practice sites range from a single physician office laboratory to large commercial laboratories.

Because of the diversity of interest in the profession, it is not an easy task to reach consensus. The few attempts that were made failed to reach agreement on titles, personnel standards, training/education. Even attempts at compromise were not successful.

AMT's position paper on licensure for medical laboratory personnel was made available to participant at last year's meeting. The conclusion reflects AMT's attitude on licensure.

> AMT reaffirms its opposition to state licensure for medical laboratory personnel unless there is consensus among all the groups representing generalist laboratory practitioners as to qualifications, titles, accreditation and certification policies. AMT reaffirms its position that licensure is a restrictive and protectionist measure and that certification is an acceptable alternative that can ensure quality in laboratory testing at less cost to the consumer. It reaffirms its belief that academic preparation at the technician and medical assistant levels is mandatory, but that the technician, either through additional education and/or experience and examination and through continuing education, be able to advance within the profession to a director position. Lack of an academic degree should not be a barrier to an individual who has initiative, interest and an innate ability to learn on the job, and who desires to advance in his/her chosen profession of medical technology.

Current state licensure initiatives in medical technology are being accelerated by one of the associations representing about 21,000 generalist medical laboratory practitioners.

The need for exchange of information between the communities of interest affected by licensure is vital; otherwise rigid personnel qualifications may apply even though technological advances may call for a new look at education and training of professionals.

These external forces that impact on the production and practice of the professionals must be considered in ongoing dialogue and cooperative venture with credentialing agencies/educators, employers and consumers.

The '90s Viewpoint

Earlier in the program I presented the AMT model at the general session on, "Two Models of Administrative Independence in Certification Agencies." As you look to developing your certification strategies for the '90s, look beyond your current certification programs and, together with the professional association and accrediting entities that make up your trinity, explore the horizon to see if there are practitioners and programs within your discipline that are not served by your groups. Look to accommodating these individuals in your ranks even though it may require some changes in your credentialing and association practices. This can be accomplished without compromising quality. To ignore the existence of such individuals is to invite new and competing groups into the credentialing/association arena. The latter, in itself, is not bad, for competition produces action which, constructively directed, is a movement for good.

AMT, for example, was born out of such need in 1939, i.e., a certifying agency for medical technologists who were ignored by existing agencies. AMT respects traditions but is not afraid to explore new horizons to fulfill a need. There are educational systems producing thousands of allied health practitioners that operate outside of the so-called "traditional"

mode of education. They are innovative and respond readily to educating practitioners to the changing needs of the health care delivery system.

In his book Private Vocational Schools and Their Students - Limited Objectives, Unlimited Opportunities, Chapter 2, titled "Social Role of Private Vocational Schools," authored by Dr. A. Harvey Pelitsky, opens with this quote by Charles Mathis, Director, Eastern School for Physicians' Aides, New York:

> Fortunately for us, we [the private vocational schools] have identified our particular goals and know what excellence is in terms of these goals, and we have established our educational program (learning through doing) in order to produce these results . . .

In a reprint of an article published in the National Home Study News Supplement, September 1973, that originally appeared in the summer issue of the magazine Change, titled "A New Look at Proprietary Schools," by Wellford W. Wilms, Project Director at the Center for Research and Development in Higher Education at the University of California at Berkeley, the statement was made:

> Until these two purposes of higher education--training and education--are clearly defined and understood, colleges and universities will probably not be successful in developing an educated and skilled person in four years. A real choice for some people should be to attend a program that provides only training and makes no pretense of educating the "whole man." At a later time in life, when he is ready, the same student could take advantage of the educational options offered by colleges and universities.

Again I quote from the article:

> Proprietary schools are likely to compete seriously with two- and four-year colleges in training the labor force of the future. To exclude them just because they make a profit is to respond emotionally to a red herring. Profit making is not the issue. The question that should be asked of proprietary schools as well as public vocationally-oriented schools is very simple: How well do they do what they say they are doing?

A study, The Future of Allied Health Education, New Alliances for the 1980s, by the National Commission on Allied Health Education, was supported by a grant from the W. K. Kellog Foundation to the American Society of Allied Health (ASAHP). Among the recommendations was the following: Educational and collaborating institutions should adopt mechanisms to facilitate the removal of unnecessary barriers to student progress.

It was AMT's hope that ASAHP would assume an active role in removing some of the barriers that impede student progress from proprietary/vocational education to higher education.

While some efforts were made in removing some of the barriers between two- and four-year colleges, only lip service, and very little of that, was given to this necessary avenue for students.

What a golden opportunity colleges and universities are missing to further educate thousands of well-trained allied health practitioners.

In planning our strategies for the '90s, AMT is working on linkages with regionally-accredited universities without walls. We want to establish a program of college credits for those successfully completing certifying examinations through the American Council on Education.

AMT will continue to address the needs of our accredited schools and programs to provide avenues of certification for their graduates. AMT will not duplicate certification efforts that are available without first consulting and encouraging existing credentialing bodies to accommodate graduates of our accredited schools and programs. If our efforts are unsuccessful, we will step in and fill the void consistent with the guidelines provided by NCHCA/NOCA. With the privilege bestowed upon me by years in the trenches of certification, let me issue a challenge to all of you to dare to be different--but accountable. It is said, "Don't be afraid to go out on a limb. That's where the fruit is."

Thank you.